FORM HCFA 250 (4-00)

EXPIRES-01-31-2002

MEDICARE QUESTIONNAIRE FOR B	ENEFICIARIE	S 65 OR OVER
NAME	DATE OF BIRTH	MEDICARE NUMBER
JOHN Q. PUBLIC	7/23/1935	987654321X
INSTRUCTIONS: This information will be read by a compute within the boxes. Use CAPITAL letters. No BLUE INK. EXAMPLE A B C 1 2 3	_	
SECTION A - INFORMATI	ON ABOUT YO	OU
1) On 7/1/2000 , will YOU be working? YES		go to SECTION B)
2) How many employees, including yourself, work for your employe	er?	
Don't know 20 or more keep less than 20		OP, go to Section B)
3) Do you have any group health coverage through your current em	ployment?	
YES NO (If NO, STOP,	go to Section B)	
Please print the name of your employer, and information about your	group health plan in ti	he spaces below:
EMPLOYER NAME	TINICI	1 1 1
MEGACONGLOMERATE	TMC	
IIABI MAIN STREET		
IA NI VITO WINI	ATE ZIP	ititi i i i i
NAME OF GROUP HEALTH PLAN		
ABC INSURANCE COM	PANY	
ADDRESS FIRST AVENUE		ш
ADDRESS	11111	
GOTHAM CITTY	Y 9 9 9	9.9.
GROUP IDENTIFICATION NUMBER	999	1117
A X 1 2 3 T F		
POLICY NUMBER [9 8 7 6 5 4 3 2 1		
SECTION B - MORE INFORMA	ATION ABOUT	YOU
1) Are YOU getting Black Lung (Coal Miner's) Medical Benefits?	1.1.1-1.1	1-1-1-1-1
YES NO If YES, Date Benefits Begar		D Y Y Y Y
2) Are YOU now getting any medical services related to an illness or	injury which occurr	ed on the job, for which
YOU have or will file a workers' compensation claim?	1 1 1-1	1 1-1 1 1 1 1
YES NO If YES, Date of Illness or Inju If YES, Insurer Name	M M D	D Y Y Y Y
I TES, insurer Name		1.1.1
ADDRESS		
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CITY STATE	ZIP	

SAMPLE

If YES, Insurer Name A C M E	covered under no	-			ility in	surano	ce?										110	10	9
ADDRESS POO BOX 7999 ADDRESS PTROPOLUTS SECTION C - INFORMATION ABOUT YOUR HUSBAND/WIFE TOT/1/2000 Mill your husband/wife be working? YES NO N/A (If NO or N/A, STOP, sign bottom of ferman to the second of the	YES 🔀	NO [If YI	ES, Da	ate of	Illness	or In	jury:	М	M	_ [6	<u> </u>	2 J.	- L	YY	Y	Y
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Don't know												Ш							
oes your husband/wife have group health coverage through his/her employment? What type of coverage does your husband/wife have under this health plan? Worker only coverage Family coverage (husband/wife) e provide the name of the employer, and information about the employer group health plan in the spaces below: EMPLOYER NAME ADDRESS CITY STATE ZIP NAME OF HEALTH PLAN ADDRESS ADDRESS ADDRESS CITY STATE ZIP GROUP IDENTIFICATION NUMBER POLICY NUMBER Four Signature Is Required AREA CODE PHONE NUMBER	ow many emplo	yees, inch	uding yo	ur husb	and/v	vife, w	ork fo	or your	husb	and/v	vife's	empl	oyer	?					
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